REPORT OF

RESIDENT ABUSE INVESTIGATING COMMITTEE

Background

1. The Sunland Training Center at Miami was officially opened to its first residents July 1, 1965. It is an approximately 900-bed institution operated by the Division of Retardation, Department of Health and Rehabilitative Services, State of Florida, for the mentally retarded. Its resident population includes virtually all age groups from nursery to advanced years. Degree of retardation varies from the profound to the slightly afflicted, and encompasses many causes. Some of its residents exhibit psychotic and delinquent behavior as well as retardation. All races indigenous to Florida are represented. The Center is located in northwest Dade County near the Broward County line, and thus convenient to both these large population centers. It was the first institution of its kind in Florida to be located in a metropolitan area. Site selection was based, in large part, upon the belief that such a Center would benefit markedly from having conveniently available the scholarastic, research and medical facilities of the Dade-Broward area as well as belief that adequate staffing and volunteer services would be more readily available in this populous area. The Sunland Center at Miami offers hospital and extended care for the profoundly retarded; training in basic living skills for the severely retarded, and education for those able to profit from it. A social service department works to coordinate Center activities and training with involved families. Voluntary services are used extensively. Many residents attend public schools during day hours. There is an emphasis on independent living for higher-level retardates and many are returned to the community as functioning citizens.

2. The Center has been plagued, since opening, by an excessively high turnover rate of employees -- particularly cottage parents (attendants) -- and resulting understaffing and undertraining. The seasonal nature of Dade and Broward employment opportunities has been a major contributing factor to turnover as employees find higher paid positions within the tourist industry during the winter months. Today, the majority of cottage parents attending the 42 individual cottage living areas are college students. Sunland has also evidenced great difficulty in providing a meaningful program for residents received with a history of emotional disturbance and delinquent behavior. The Center is neither designed nor equipped to function as a jail. It is not staffed for the treatment of mental illness as distinguished from mental retardation. Yet, on occasion, circumstances dictate that it must receive and attempt to help this type of individual.

3. Over the years there have been periodic allegations of resident abuse. In 1969, the superintendent immediately preceding the incumbent resigned when it was disclosed that he had confined two of his charges in a cell improvised from a large trailer. In April, 1971, the Florida Division of Mental Retardation and the Dade County State Attorney's Office commenced an intensive investigation into resident abuse upon the complaint of a former state employee who had been conducting a training program at the Center. This investigation was terminated in October, 1971, with the conclusion that:

(a) Although there were infrequent and isolated cases of abuse, these were in no way representative of the institution as a whole;

(b) The superintendent, in each reported case, dealt swiftly and fully with employees involved, taking adequate disciplinary action (including discharge).

4. The present investigation has its genesis in an attempt by the present superintendent, Dr. Arnold Cortazzo, to reassign the duties of a professional employee, Dr. Dennis Edinger. Dr. Edinger, exercising his right under departmental personnel rules, filed a formal grievance with the Division of Retardation protesting his reassignment. A grievance committee composed of W. S. Samford, Superintendent, Sunland Training Center at Fort Myers; Harry Howell, Superintendent, Sunland Training Center at Gainesville; and Leslie Alker, Psychologist, Sunland Training Center at Miami, was appointed to hear the grievance. The Grievance Committee began receiving testimony on March 8, 1972, and submitted its report on March 28, 1972. The conclusion of the Grievance Committee was that the proposed transfer was not justified, in that it had not been procedurally supported. The Grievance Committee noted, however, that during the course of its hearing it had uncovered what it considered to be a "highly explosive" situation at the Sunland Training Center in Miami involving resident abuse with apparent knowledge and condonation of top administration. The Grievance Committee stated that "testimony brings out there is unquestionable need for high-level remedial action NOW"! Following receipt of this report on March 31, 1972, Mr. Jack W. McAllister, Director, Division of Retardation, suspended from their positions at Sunland, the following individuals:

Dr. Arnold Cortazzo, Superintendent

Mr. John Acosta, Director of Cottage Life

Dr. Dennis Edinger, Staff Psychologist

Mrs. Mary Rayder, Cottage Group Supervisor

Mr. George Thompson, Cottage Supervisor

Mr. Simmie Strickland, Cottage Supervisor

Mr. John L. Coachman, Cottage Parent

Each suspended employee was told that he (or she) was charged with misfeasance, malfeasance, negligence, and contributing to the abuse of residents, and that the suspension would be for a period of 30 days during which an investigation would be conducted. They were advised that if the charges prove unsubstantiated they would be reinstated with full pay, but that if the charges were substantiated, removal would be permanent and further disciplinary action "will be likely".

The Resident Abuse Investigating Committee.

5. Immediately following imposition of the suspensions, Mr. McAllister proceeded to assemble a Resident Abuse Investigating Committee comprised of persons knowledgeable in the field of retardation and independent of the Sunland Training Center at Miami and the Division of Retardation. The following persons accepted appointment to the committee, convened in Miami the evening of April 4, 1972:

Mr. Abiah A. Church	Attorney at Law, Miami, Florida; Chairman, Sunland (Miami) Advisory Committee, Florida Association for Retarded Children.
Mr. Edward Johnstone,	Fort Lauderdale, Florida; Consultant, President's Committee on Mental Retardation.
Dr. Darrel J. Mase,	Gainesville, Florida; Dean Emeritus, College of Health Related Professions, University of Florida.
Dr. Jack G. May, Jr.	Tallahassee, Florida; Associate Professor of Psychology, Florida State University; President, Florida Association for Retarded Children.

Mr. Allen Menefee, Tallahassee, Florida; Associate Professor, School of Social Work, Florida State University.

Mrs. Mary Ann Price, Jacksonville, Florida; Protective Services Consultant, Bureau of Children's Services, Division of Family Services.

Dr. Todd Risley, Lawrence, Kansas; Associate Professor of Human Development, University of Kansas, Member, Ethics Committee, Division 25, American Psychological Association.

Dr. Philip Roos, Arlington, Texas; Executive Director, National Association for Retarded Children.

Dr. Clyde D. Schoenfeld, M. D., Miami Beach, Florida; President Dade Association for Retarded Children.

Mrs. Dolores Norley, West Palm Beach, Florida; Chairman, Residential Service Committee, Florida Association for Retarded Children, and Miss Beverly Rowan, attorney at law, associated with the Mailman Center for Child Development, Miami, Florida, were named as observers.

6. In its first session, the Committee (a) received copies of pertinent documents from the files of the Division of Retardation; (b) organized itself, electing Mr. Abiah A. Church, chairman, and Dr. Jack G. May, Jr., vice chairman; and (c) adjourned so that its members might study the documentation furnished.

7. Reconvening the morning of April 5, the Committee received its written assignment from the Division of Retardation, a copy of which (dated April 5, 1972) is appended as Exhibit "A". As set forth therein, it is the Committee's assignment to:

(1) determine whether or not the punishment practices that have existed in Flagler Cottage, Achievement Division, can in fact be considered abusive

(2) if so, determine whether abusive practices as reported in the

Log Books of Flagler Cottage exist in Leon and Desota cottages

(3) determine by spot check if prescribed punishment procedures are or have been utilized in other divisions at Sunland Training Center, Miami

(4) if the Achievement Division appears to be the focal point for administering sanctioned or prescribed resident abuse, then the Division of Retardation needs to know:

(a) why has the situation developed

(b) what individuals are responsible for instituting the abusive procedures

(c) what is the degree of responsibility of:

(1) cottage parents who administered abusive punishment

(2) supervisors who direct or oversee the administration of the techniques

(3) program directors who prescribe or otherwise authorize the continuation of these procedures or their superiors up to and including the superintendant of the Sunland Training Center, Miami

(4) the Division of Retardation in terms of administration or policy strengths or weaknesses relating to detection, monitoring or taking remedial action against such abuse practices.

(5) If it is determined that abuse exists at Miami Sunland Training Center, the Committee should attempt to determine the accountability in this particular situation of those employees and/or officials who conceived, authorized, directed, condoned or administered abusive practices or techniques with regard to Sunland Training Center, Miami, residents.

(6) If such abuses exist, what recommendations does the Resident Abuse Investigation Committee have for remedying the present situation and preventing its future occurance.

8. After an examination and discussion of its assignment, the Committee divided itself into three subcommittees as follows:

Subcommittee No. 1 - Resident Abuse: Dr. Schoenfeld, chairman
Mrs. Price
Mr. Menefee

This subcommittee was charged with examining specific charges of resident abuse within the institution. Its assignment was to attempt to verify charges; to determine the identities of those involved; the frequency, severity , and location of abuse, to examine medical records and practices.

Subcommittee No. 2 - Achievement Division Program: Dr. Risley, chairman
Dr. Roos

This subcommittee was charged with examining the program instituted by Dr. Edinger within the Achievement Division (Flagler, Leon and Desoto cottages). Its assignment was to determine whether the program was soundly conceived and administered, to determine whether apparent abuses were, in fact, accepted therapeutic or educational techniques, and to fix responsibility for any shortcomings.

Subcommittee No. 3 - Administrative Policies and Practices: Dr. Mase, chairman
Dr. May
Mr. Johnstone

This subcommittee was charged with examining the administrative policies and practices of the Sunland Training Center at Miami to determine:

(a) whether policies of the Center are clearly expressed to prohibit resident abuse.

(b) whether the administrative structure developed and staffed by the superintendent is adequate to insure the implementation of policy

(c) whether there have been breakdowns in administrative control of the Center, and if so, where, and why

(d) whether, if abuse is found, if it is attributable to failures of administration

(e) if there has been a failure in administration, who is responsible

(f) what, if anything, can be done to correct the situation

The division of the committee into subcommittees was deemed necessary by the limitations of time, the committee having in mind that its report was needed by the Division of Retardation prior to the expiration of the 30-day suspension period effectuated for the seven state employees above-named.

9. On April 5, 1972, the committee designed Miss Rowan coordinator to receive reports of alleged abuse and arrange interviews with the committee, and called upon any person having knowledge of abuse incidents at the Center to provide information.

10. Approximately 71 individuals were interviewed by the committee or its appropriate subcommittee on April 5, 6, and 7. (List of those interviewed is attached as Exhibit "B"). Additionally, statements were taken by telephone from a small number of anonymous callers who wished to report incidents or to support the superintendent, but who stated that they did not wish to be identified. (While anonymous statements were taken in an abundance of caution that no lead be overlooked, none of the conclusions or recommendations set forth in this report are

based upon such statements). This committee did not enjoy the power to compel the attendance and testimony of witness or to examine under oath. Nevertheless, it found parents, residents, consultants, interested citizens, and the Sunland staff, including those suspended, most cooperative and, in most cases, full and frank in their testimony. Where participants were represented by counsel, counsel proved most helpful producing facts useful to the committee. The illness of Dr. Cortazzo, which commenced on April 5, 1972, required the committee to recess on April 7 without having heard his testimony. On April 11, 1972, the committee (Messrs. Church and Johnstone not present) convened at the Palmetto General Hospital where Dr. Cortazzo was recuperating and questioned him for approximately two hours. On April 15, 1972, Dr. Cortazzo, at his own request, met further with Mr. Church and Dr. Schoenfeld at Mr. Church's home and an additional approximately three hours of testimony was given. All of Dr. Cortazzo's testimony was recorded and listened to by committee members not present when the testimony was given. Much (but not all) of the testimony of ther witnesses was recorded, and the tapes of such testimony are being delivered to the Division of Retardation simultaneously with this report. Each witness interviewed was advised that he could refuse to testify if desired; also that he might be represented by counsel if he desired. Witnesses were also told that, if they so requested, their testimony would not be recorded. No witness declined to permit recording. In addition to Dr. Cortazzo, other witnesses interviewed at length include Dr. Edinger (approximately 10 hours) and Mrs. Rayder (approximately 3 hours).

11. During its investigation committee members examined the original logs from Flagler and other cottages; the report and supporting data of the grievance committee dated March 28, 1972, a volume of internal memoranda supplied by Mr. McAllister and by Dr. Cortazzo; a personal diary maintained by Mr. Stokesberry; and the personnel records of certain individuals involved. In certain instances, references and educational background information were checked by telephone with

appropriate sources. Visits were made by committee members to the Achievement Cottage, and other residential areas of the Center.

12. At the end of each day, and following the conclusion of all testimony, the full committee met to review, exchange, and cross-check information compiled by the separate subcommittees. The findings and facts, conclusions and recommendations which follow represent the unanimous opinion of the committee after full review and discussion of all testimony and pertinent documents.

Abuse of Residents

13. It is the opinion of this Committee based upon the testimony given and documents examined that the punishment practices that have existed in Flagler Cottage, Achievement Division are, in fact, abusive. The following incidents, all considered abusive, have been confirmed by eyewitness reports and entries in official records to have occurred in Flagler Cottage during the period January 1 1971 through January 25, 1972.

(a) Forced public masturbation.

(b) Force public homosexual acts.

(c) Forced washing of mouth with soap and liquid detergent as punishment for lying, abusive or vulgar language, or, at times, for speaking at all.

(d) Beating administered with wooden paddle 1/2 inch thick. Residents received "10 licks" as standard punishment for running away; one resident received "35 whacks" for cumulative bad behavior.

(e) Excessive and unnecessary use of leather or fabric restraints, and restrictions on personal freedom. One resident was restrained for more than 24 hours except for meals and bathroom; another was forced to sit in a bathtub for most of

two days. These restrants were used as punishment and not for the purpose of preventing injury to self or others.

(f) Made to wear bizzare clothing -- a boy was required to wear female underpants.

(g) Excessive use of seclusion. Although "time out" is an accepted technique for controlling certain types of disruptive behavior, it was often misused in Flagler Cottage. Seclusions as long as four hours (much too long) were recorded. The seclusion rooms are barren and unpadded. Three residents testified that they were not permitted to leave seclusion to use the bathroom.

(h) Public shaming by forcing one resident to wear a sign proclaiming him to be "The Thief" and to be addressed by other residents and staff personnel as "The Thief".

(i) Withholding of food as punishment.

(j) Forced lack of sleep as punishment. In one case a boy was punished for sleeping while he was receiving several different sedatives which could be expected to cause drowsiness.

(k) Use of military disciplinary measures as punishment, specifically the "lean and rest" position (the "up" position of a push-up) and a squatting position. Also, residents required to confine themselves to a small square of floor or to a certain chair for excessive periods of time.

(l) Resident forbidden to speak, other than: "yes, sir"; "no, sir"; "I have to potty"; for an indefinite period of time.

(m) Resident required to hold feces-stained underwear under his nose for approximately 10 minutes as punishment for incontinence.

(n) Resident bathed with cleanser as punishment for fecal incontinence.

(o) Resident made to lie in urine-soaked sheets as punishment for repeated incontinence.

(p) Punishment of all residents for incidents such as finding an unexplained pill or theft of an object.

(q) Denial of visitation privileges.

14. Time available did not allow for a thorough investigation of possible abuse within Leon and Desoto cottages or in cottages outside the Achievement Division; however, the following incidents of abuse within Desoto and Leon were identified:

(a) Resident's arm twisted to the point where the swelling was still visible the following day.

(b) Resident's finger bent back to the point where it was observed to be swollen two days later.

(c) Resident dragged into seclusion by her hair.

(d) Resident restrained in contorted position for unjustified period of time.

15. In residence areas outside the Achievement Division, the following incidents of abuse were identified:

(a) Resident slapped and beat with belt.

(b) Ten year old boy accidentally locked in a linen closet; his absence not noted for 12 to 16 hours. (Four employees discharged following this episode; two were reinstated via appeal; two did not appeal.)

(c) Thirty-seven year old woman resident twice received multiple bruises whose appearance suggested they had been inflicted with a ruler or similar object.

16. While not constituting physical abuse, the following conditions (which the committee feels are mentally abusive and dehumanizing) were found to exist within and, to some extent, outside the Achievement cottages:

(a) Lack of programming, resulting in profound boredom and deterioration.

(b) Complete lack of privacy.

(c) Unattractive surroundings with inadequate furniture.

(d) Public humiliation.

(e) Nakedness.

(f) Lack of any effective means for residents to express their grievances.

17. The committee's investigation also revealed instances of apparent neglect or indifference which resulted in or contributed to death or needless suffering of certain residents, as follows:

(a) Admission to infirmary of above-mentioned 10 year old boy who had been locked in linen closet over-night with only the notation "for observation".

(b) A blind, retarded child was observed by her family to lose 20 lbs. in three months. She was admitted to the infirmary and given two trays each meal. She gained 8 lbs. in 17 days.

(c) A 21 year old boy was admitted to the infirmary with "dehydration and pneumonia". The admission note attributes this to the extreme environmental heat and a breakdown of airconditioning in his cottage. Records show he had lost 20 lbs. over the preceding year. The patient's mother saw him on the 6th infirmary day. She was distressed at his appearance and took him to another hospital. He died 12 hours later. In the

infirmary, he had not received a chest x-ray or intravenous fluids. The autopsy report described dehydration, pneumonia and blood clots in the lungs.

(d) A resident ran away from his cottage and drowned in a nearby canal, outside Center grounds.

18. Although limitations of time did not permit the Committee to conduct an investigation in sufficient depth to reach a firm conclusion, it is the Committee's impression that abuse outside the Achievement Division is limited to random occurrences arising from occasional anger or the frustration of inadequately trained personnel, and that generally, limited corrective measures are taken promptly. Only within the Achievement Division did the Committee find "programmed abuse".

Evaluation of the Program on the Achievement Division Cottages.

19. The incidents of abuse described above (particularly in paragraph 13) were largely prescribed by responsible personnel of the Achievement Division, and it is the Committee's opinion that they were no less abusive because conceived (however erroneously) to be "behavior shaping devices". A detailed examination of this program in both concept and application leads to the conclusion that what started out as an attempt to create a superb behavior modification program degenerated -- with the best of intentions of those involved -- into a bizarre, abusive, and ineffective system of punishment. These practices deviated from usual cases of abuse found in institutions of this type in the following respects:

(a) They were systemmatically applied as part of a total "program".

(b) They were condoned -- and in some cases encouraged -- by some supervisory and professional staff.

(c) They were regularly recorded in daily living unit logs.

(d) They included unusual practices, such as forced public sexual displays.

20. The token program on the Achievement cottages was a combination of at least two established token reinforcement systems. The definitions of appropriate and inappropriate behaviors and the approximate magnitude of tokens grained or lost for each were adapted from the token economy program for trainable retarded girls operated by Dr. James Lent at Parsons, Kansas. The overall system was organized and operated similar to the program for juvenile delinquents at the National Training School for Boys operated by Harold Cohen, Both of these programs are established, successful, and have been used as models for similar programs in many institutions throughout the country. However, in actual operation, Dr. Edinger's program lacked one vital element of these and most other successful token systems: precise and current monitoring of the improvement of each resident's individual problem behaviors. It appears that the overriding goal of the program was research into some rather esoteric questions of statistical models for economic analysis. (It should be noted that there is nothing wrong in pursuing such research goals. However, such goals were irrelevant to the pressing problems which were continuously present in these cottages.) Consequently, little time and attention was devoted to the collection and analysis of information on particular behaviors.

21. In operation, it appears that Dr. Edinger's token program had one even more serious deficit in its structure: its organization into separate "phases". In Phase Two, the resident could exchange his tokens for a large and diverse menu of items and privileges. Thus in this phase, by earning sufficient tokens, a resident could participate in a relatively rich and varied life both in and out of the cottage. However, when a resident became "out of control" or when he initially entered the program (usually because he was "out of control" in his previous cottage) he would be placed in Phase One in which no items or privileges could be purchased with tokens. Thus, during the very time when a resident would need the strongest and most immediate reinforcement to control

his behaviors, he would be placed in the Phase One program which had few immediate reinforcers. In fact, it is only after the resident's behavior had been well under control for a considerable period of time -- such that he had accumulated a large number of tokens -- that he was allowed back into the Phase Two program; where those tokens could become"meaningful" through the opportunity to use them to purchase various items and privileges.

22. In summary, it is almost inevitable that this token economy program would be plagued with frequent problem behaviors from residents in the Phase One program. In addition to this (or in recognition of this), some residents were even completely removed from the token economy program. Thus, many children required special programs when their problem behaviors could not be adequately handled by the (poorly designed) general token economy program in the Achievement cottages. (It should be noted that the flaws in this token program were present in the token system in use on these cottages at the time Dr. Edinger assumed responsibility. He did not, however, change these aspects during the 16 months of his direction of the program).

23. The Special Programs instituted for particular residents of the Achievement cottages are the focal point of this investigation. The attendants were instructed to follow three general guidelines in dealing with the recurrent behavior problems which were not adequately remediated by the token economy: (a) They were told to emphasize the natural consequences of the behavior in responding to the deviant behavior of the residents. (b) They also were told that within this guideline they were to devise their own immediate response to problem behaviors for which specific instructions had not been provided them. (c) And finally, they were instructed that they were to follow through on every contingency (promise or threat) that they verbalized to the residents. The incidents which lead to this inquiry evolved almost inevitably out of this method of devising special programs for problem residents.

24. From examining the log entries for the Achievement cottages, and from the interviews with the parties involved, we have determined that unusual procedures were being used in these cottages; that these unusual procedures, although infrequent, were systematically employed and even within the context of the problems and setting of these cottages, these procedures were, in most cases, unnecessary, unwarranted, probably ineffective, and completely unjustified. The use of such procedures as the "lean and rest" position, spanks, prolonged seclusion, prolonged physical restraints, "washing the mouth" with soap; public humiliation by forcing residents to wear special attire or engage in public masturbation or other sexual acts are not normal therapeutic or educational procedures. They have neither been suggested, researched, nor promoted in behavior modification literature or in the literature of any other modern therapeutic or educational methodologies.

25. On the Achievement cottages, these unusual procedures were not instances of random cruelty, but neither were they the result of a prescriptive program derived from a body of literature. They were the result of well meaning, but poorly trained personnel attempting to deal with problems which they perceived as dangerous in a situation totally isolated from outside monitoring, guidance, and intervention. It appears that in each case mild forms of these unusual procedures were initiated by the cottage parents from their own imagination or from the precedent set by the covert use of some level of these procedures on these cottages in the past. In most cases, the use of each procedure was dutifully logged and probably otherwise reported to Mrs. Rayder and Dr. Edinger. If the unusual procedure appeared to follow the three general guidelines for dealing with unique problem behaviors, they were either actively approved -- and instituted as a general pattern for dealing consistently with that behavior problem for that resident by Dr. Edinger and Mrs. Rayder -- or were at least passively accepted. What appeared to result then was that on the next instance of the behavior, the staff member would employ a slightly more extreme form

of the special procedure which would, in turn, receive approval or acceptance. In this way, quite extreme procedures evolved in gradual steps from the spontaneous initiation of less extreme procedures by the cottage staff, until by the latter part of 1971, a pattern had been established of dealing with recurrent problems by escalating the intensity of whatever procedures happened to be in use for a particular resident. This designation of how these incidents came to arise in these Achievement cottages should not be interpreted as an attempt to condone or justify their use, but to relate their occurence to the problems in the administration and staffing arrangements in these cottages and in the institution.

26. The evolution of these procedures could only have occurred in the complete absence of monitoring, guidance, and interventinn by the administration and professional personnel in Sunland, Miami. The cottage staff could implement these procedures in good faith -- under the assumption that they were beneficial to the residents and acceptable to society at large -- only because they were isolated from professional interaction with other personnel in the institution. The absence of a serious program of orienting and training new employees and the lack of regular in-service training sessions were a contributing factor to this situation. In spite of the apparent religious entry of most of these events in cottage log books, it appears that Dr. Edinger and Mrs. Rayder and therefore, the rest of the staff, rather systematically discouraged communication about their program with other institutional personnel and with the outside professional consultants employed by the institution. The question remains, however, in spite of this, of how Dr. Cortazzo could have allowed such nearly total isolation to have developed. Thus, the apparently incompatible facts of abusive procedures being used by a staff apparently dedicated to the welfare of the residents could occur because of the lack of formal procedures for training and monitoring of the staff by persons outside the little world of the Achievement cottages.

27. In such an isolated setting, the prime developer of these programs would have had to have extensive background and training in acceptable and effective ways of dealing with the problems which are presented by the residents of these cottage. This committee has made a close inspection of the verbal reports of Dr. Edinger regarding his training and experience and the training and experience listed on his employment application. We have found disturbing discrepancies between Dr. Edinger's description of his experience and actual events. Dr. Edinger came to Sunland, Miami, to establish a behavioral research laboratory. His qualifications for this task, although adequate, were not as extensive as either his verbal statements or the documents he provided suggested. His vita indicated training by several eminent researchers -- who, upon inquiry -- vaguely remembered a brash young man who visited their laboratories on several occasions. In conversation, his verbal statements implied that he was trained by, or had extensive ineraction with several other authoirities -- who also vaguely remembered momentary conversations which terminated as soon as they found a polite excuse. Such discrepancies between verbal reports and actual events have apparently been characteristic of Dr. Edinger's behavior beginning with the earliest reports of his graduate education.

28. In October of 1971, Dr. Edinger was given responsibility for the program and management of the Achievement cottages. In December of 1971, he was also made responsible for the Nursery and Semi-Ambulatory cottages. These were (and are) the most troublesome divisions within the institution. Dr. Edinger had little experience with -- and certainly no training in -- dealing with the type of resident present in the Achievement cottages. Although he now admits to this, it has become apparent from our interviews that such humility is uncharacteristic of him and, in fact, was not evident when he was offered the responsibility of Achievement cottages. It seems Dr. Edinger's verbal skills and tendency to exaggeration resulted in his being given a level of responsibility inappropriate

to either his maturity or his training. He isolated himself from his previous professional mentors and from local professional peers. He was able to functionally isolate his activities, plans, and research goals from other professionals at Sunland, Miami. Thus, he was given responsibility for which he was unprepared, and allowed to operate in the absence of any peer review from his profession or from his superiors in the institution. And finally, it should be noted that several of the professional consultants employed by Sunland, Miami, advised against hiring Dr. Edinger in the first place, and emphatically advised against giving him responsibility for the Achievement cottages. It is apparent that Dr. Cortazzo accepted Dr. Edinger's descriptions of his ability and training without close inspection of either.

29. Dr. Edinger is, however, an intelligent and energetic young man who, when faced with a problem for which he has been trained has performed in an exemplary manner. His efforts in the nursery and semi-ambulatory programs at Sunland, Miami have been highly regarded by almost everyone. His training at both the University of Florida and at John Hopkins was largely in procedures related to this population.

Administrative Policies and Procedures

30. The Committee determined that the policies of the Sunland Training Center at Miami and of its Achievement Division clearly prohibit abusive practices and require the reporting of abusive incidents observed. Verbal as well as physical abuse is forbidden. There is, however, little evidence that the policies so clearly stated in the Center's rules and regulations are forcefully communicated to employees. There appears to be no consistent program of orientation and training of new cottage parents prior to assignment to cottage responsibility. There is apparently no periodic in-service training to reinforce knowledge of rules and regulations. Employee turn-over is so frequent that on-the-job training by

older, proven employees is unreliable. There appears to be a pervasive feeling among employees that some physical punishment is tolerated by the administration regardless of what the written rule may be. One former cottage parent testified that she was instructed by an older employee as to punishment that might be inflicted without leaving a bruise.

31. It is the opinion of the Committee that the present unfortunate situation of resident abuse existing within the center for a period of at least six months is in large part attributable to a near-complete breakdown of administrative control by the superintendnet. The following factors are both causative and symptomatic of the breakdown:

a. Constant changes in the Center table of organization, and the frequent assignment of personnel to duties inconsistent with the table of organization.

b. The practice of attempting to cure incompetence or to punish misconduct by transfer to other duties rather than by direct remedial action, disciplinary suspension, or discharge.

c. The sudden ascent or descent of individual executives or professionals in the scale of authority and responsibility without apparent relation to job performance.

d. The involvement of wives of key administrators in sensitive Center positions (e.g. Mrs. Cortazzo was on center full-time as a volunteer; Mrs. Acosta served as secretary to Dr. Cortazzo).

e. The frequent assignment of authority and responsibility well above the level of employment (job classification).

f. The abrupt withdrawl of responsibility and authority from individuals in disfavor.

g. The apparent reluctance of administrators to lay the proper

foundation for disciplinary action or discharge

h. Extreme vagueness on the part of many employees as to the extent of their responsibility and authority.

i. Confusion resulting from simultaneous operation by the superintendent of an "open door" policy and the creation of an "essentially autonomous" division which enforced rigid chain of command requirements.

j. Failure to adequately check the qualifications of persons assigned to key positions.

k. Lack of a consistent orientation and in-service training program.

l. Failure of the superintendent to heed repeated signs over a period of months that something was amiss within the Achievement Division.

m. Existence of contradictory statements of policy relative to corporal punishment.

n. Lack of response to advice generously bestowed by consultants and advisory committees.

Accountability for Abuse

32. There is no question that cottage parents implemented abusive practices on Flagler Cottage (and probably other Achievement units) as part of a systematic attempt to control resident behavior. Mr. Coachman, Mr. Maas, Mr. Strickland and Mr. Thompson readily admitted their direct participation in the practices. Mrs. Willomena Wallace, Mrs. Mary Brooks, Mrs. Mary Scott and Mrs. Davis were identified as having participated in abusive acts, but information is inconclusive and warrants further investigation. In the cases of Coachman, Maas, Strickland and Thompson, it should be noted that these men -- and probably others -- acted in

good faith on the basis of their direction from superiors and on the assumption they were complying with professionally sanctioned principles. They meticulously recorded their actions in the unit log. It also should be noted that they did not view their actions as abuse, and, in fact, when two of these men (Coachman and Strickland) were observed by Committee members on Flagler, they interacted with residents with obvious warmth and genuine affection. It is not surprising that cottage parents would discipline residents by using practices which may be quite compatible with child rearing practices common in their own sub-culture (e.g. paddling and washing mouth out with soap) when specifically instructed by their superiors to do so.

33. The unit supervisor, Mrs. Rayder, who later was assigned administrative direction of the division, was fully aware of the practices used and must have been involed in their implementation. In spite of familiarity with institutional philosophy and specific policies regarding abuse, she joined forces with Dr. Edinger in mounting a program which relied heavily on abusive practices. She did not alert administrators to these practices. Although her intent -- as that of all participants in this unfortunate incident -- appears to have been to help the residents, she played a key role in a highly destructive program.

34. Dr. Edinger, as Division Director and principal author of the program, had major accountability for the abusive practices on the Division. All log entries were directly available to him on a daily basis, and he insisted on careful documentation of all aspects of the program. Hence he was either grossly negligent for failing to monitor what he himself recognized as a potential dangerous situation, or he actively condoned practices which he later admitted to the Committee were unacceptable (e.g. the forced public sexual displays). Dr. Edinger was aflame with pseudoscientific zeal, but he was not candid in reporting punitive practices to either consultants or the superintendent.

35. The cottage life director, Mr. Acosta, was fully aware of the punitive components of the Flagler program, and was probably involved in their implementation. Although familiar with institutional philosophy and policies, he apparently condoned these practices. The Committee could find no evidence that he tried to dissuade Dr. Edinger or his staff from using questionable practices or that he alerted Dr. Cortazzo to the situation, in spite of Dr. Edinger's claim that Mr. Acosta was his "shadow" during early stages of the Flagler program.

36. There is reasonable doubt that Dr. Cortazzo was aware of some of the abusive practices on the Achievement Division. Information reaching him was in some cases, selective, incomplete, and conceivably purposefully altered or blocked. Although the Committee noted irregulairty in at least one memo and heard testimony suggesting the possibility of altered or duplicate unit logs, no credible evidence was heard supporting this theory. Dr. Cortazzo's initialing the Flagler log on one occasion suggests either awareness of at least some abusive practices or negligence in not reviewing critical log entries immediately preceding his signature, particularly when his visit was a follow-up to a phone call reporting abuse in that cottage.

37. Dr. Cortazzo is obviously deeply opposed to resident abuse. His past performance reflects repeated efforts to eliminate abusive practices. In the case of the prescribed and documented abuse in the Achievement Division, however, he failed to take remedial action until a totally unacceptable situation had been in existence for many months. Evidence indicates he had awareness of some problems on the Division, but it is unlikely that he knew or energetically sought to discover the extent or the seriousness of abuse. Dr. Cortazzo's contribution to the abusive incidents which developed within the Achievement Division can be summarized as: (a) fostering a chaotic administrative climate; (b) delegating responsibility for a potentially explosive program to an unqualified and inexperienced person (Dr. Edinger); and (c) failing to respond quickly enough and strongly enough to mounting indications of abuse.

38. Even though the Committee was not charged with evaluating Dr. Cortazzo's total performance as superintendent, it was apparent that he has successfully innovated a number of productive programs; that he has established viable relationships with the professional community; and that he has gained the confidence and admiration of many parents and staff members.

39. The Commmittee was unable to explore the possible implication of other staff members with abusive practices because of time limitations. According to the table or organization, it would appear that Mr. Stokesberry, who seems to function as an assistant to the superintendent, would carry some responsibility and accountability for the Achievement Division. The table of organization seems to have little relationship to actual practice, however, and no conclusive evidence was available regarding Mr. Stokesberry's involvement. It would also appear that the Center's medical department has remained remarkably non-inquisitive with regard to those instances of fairly obvious resident abuse which came to its attention because of injuries serious enough to require treatment. There is no conclusive evidence of negligence; but there is enough evidence to warrant further evaluation of this department's personnel and performance.

40. Ultimately, of course, the Division of Retardation is accountable for practices within the institutions for which it is responsible. The Committee did not have the opportunity for evaluation of the Division's operation. Policies of the Division, if followed, would help prevent or remedy cases of abuse. Evidence was presented to the Committee by the Division's Director, Mr. McAllister, which indicated that, at least in one instance, abuse reported by an employee during an exit interview had inadvertently not been reported by a clerk in the Division's staff. Hence, although procedures exist which incorporate mechanisms for alerting Division staff to abusive practices, these procedures are not always effective.

41. The basic sources of information available to the Division are communication from Superintendents and direct contact with institutions by Division staff. In this particular instance, Dr. Cortazzo did notify the Deputy Director and the Personnel Director of the Division of Retardation, but only after the situation had deteriorated to an intolerable degree over a period of months, and after State staff had become aware of abusive practices as a result of employee grievance procedures. At about the same time Division staff probably contributed to the delay in discovering the existence of clearly prescribed and documented abusvie practices. As soon as he was alerted to the existence of these practices, Mr. McAllister did, of course, take immediate action, by suspending employees suspected of resonsibility for abuse incidents, installing a temporary administration, and appointing this committee.

42. During its investigation, the Committee encountered numerous cases of individuals (parents of residents and employees) who indicated that they knew of abuses on the Center, but that they feared for their children or for their jobs if they came forward to testify. The Committee believes that these fears are generally unfounded, but non-the-less real to the persons involved. This Committee feels that this fact needs to be taken into account in any system established to strengthen abuse detection systems.

43. During the course of its investigation, the Committee received testimony indicating that there exists at theCenter a problem of drug diversion and drug abuse. This problem was neither within the committee's assignment nor did time allow the development of facts. The Committee nevertheless recommends an immediate and full-scale investigation of this possibility be instituted.

44. Recommendations are submitted in two parts: (1) Recommendations concerning personnel presently suspended, and (2) Recommendations concerning policies and practices to be implemented by the Division of Retardation and the Miami Sunland Training Center to prevent abuse.

45. Recommendations concerning personnel:

46. There is no question that cottage parents implemented abusive practices on Flagler Cottage (and probably other Achievement units) as part of a systemmatic attempt to control resident behavior. Mr. Coachman, Mr. Strickland and Mr. Thompson readility admitted their direct participation in the practices. It is important to note, however, that these men -- and probably others -- acted in good faith on the basis of direction from their superiors and on the assumption they were complying with professionally sanctioned principles. They meticulously recoded their actions in the unit log. It should also be noted that they did not view their actions as abuse, and that, in fact, when two of these men (Coachman and Strickland were observed by Committee members on Flagler, they interacted with residents with obvious warmth and genuine affection. In view of these circumstances, it is the recommendation of the Committee that the suspended cottage parents and supervisors be considered eligible for retention in the service with suitable repr mand, provided they are given appropriate retraining and assignments under adequate supervision.

47. The unit supervisor, Mrs. Rayder, who later was assigned administrative direction of the division, was fully aware of the practices used and must have been involved in their implementation. In spite of familiarity with institutional philosphy and specific policies regarding abuse, she joined forces with Dr. Edinger in mounting a program which relied heavily on abusive practices. Although her intent -- as that of all participants in this unfortunate incident -- appears to have been to help the residents, she played a key role in a highly destructive program.

48. Dr. Edinger, as Division Director and principal author of the program, had major accountability for the abusive practices on the Division. All log entries were directly available to him on a daily basis, and he insisted on careful documentation of all aspects of the program. Hence he was either grossly negligent for failing to monitor what he himself recognized as a potentially dangerous situation or he actively condoned practices which he later admitted to the Committee were unacceptable. Dr. Edinger was aflame with pseudoscientific zeal, but he was not candid in reporting punitive practices to either consultants or the superintendent.

49. The Cottage Life Director, Mr. Acosta, was fully aware of the punitive components of the Flagler program, and was probably involved in their implementation. Although familiar with institutitional philosphy and policies, he apparently condoned these practices. The Committee could find no evidence that he tried to dissuade Dr. Edinger or his staff from using questionable practices or that he alerted Dr. Cortazzo to the situation, in spite of Dr. Edinger's claim that Mr. Acosta was his "shadow" during the early stages of the Flagler program.

50. For the above reasons, the Committee sees no future role in this institution for Mr. Acosta, Dr. Edinger, or Mrs. Rayder.

51. As a result of extensive investigatinn and examination of evidence, it is the opinion of the Committee that the superintendent does not presently exhibit the executive skills necessary to properly and adequately administer the Sunland Training Center, Miami. However, the Committee recognizes Dr. Cortazzo's positive contributions to the Center with respect to programs, public relations, personal obligation to residents, attraction of grant monies and scholarly efforts. It is felt that, (1) There must be some disciplinary action against the superintendent . If this action is less than dismissal, then (2) Dr. Cortazzo must accept direction and administrative reform from the

Division of Retardation. This would require that the Division be willing to provide an immediate review of the present structure, a re-evaluation of the administrative staff, and quite probably a re-assignment of duties and responsibilities for the Center. It must provide periodic on-site visits by top-level Division administrators to review administrative practices and policies, to participate in management cabinet meetings, and to periodically sample the communication channels within the institution and (3) that Dr. Cortazzo be placed in a probationary status for a reasonable period of time, during which time a decision be made as to whether he can function effectively under these conditions.

52. The Committee's investigation revealed many tales of Center staff intrigue. Also that lines of communication and authority have been distorted because of the assignment of wives of key personnel to sensitive positions within the Center. It is recommended that policies be adopted prohibiting the utilization of husband-wife teams in supervisory or policy making or otherwise sensitive positions whether on an employed or voluntary basis. This recommendation is not intended to disparage the utilization of husband-wife teams as cottage parents.

53. There is evidence to suggest that there are others within the institution who may have had various levels of involvement or knowledge of abusive practices. Time did not permit a thorough evaluation of their involvement. It is therefore recommended that the Division of Retardation continue to investigate particularly those Cottage personnel mentioned in this report, as well as other Center personnel in these categories. This investigation should include administrative staff such as Mr. Stokesberry, Mr. Alker, Mr. Gustine, Mr. Davis, Mr. Murray and the medical department as a whole.

54. With regard to preventive courses of action, the following recommendations are submitted,

55. It is noted that the Florida Association for Retarded Children (FARC) and the Division of Retardation have already developed the machinery to establish a statewise advocacy program (Citizen Advocacy Program for the Retarded). This program will rely heavily on volunteer manpower but will be coordinated by paid staff at local and state levels. Funding is to be via federal monies. It is recommended that the Director of the Division of Retardation proceed immediately to negotiate with FARC the framework within which this program will monitor for abusive practices. This framework should include the following features:

(1) Unannounced as well as announced visits to institutions

(2) Free access to records

(3) Required periodic interviews of key personnel

(4) Ability to receive priviledged testimony from retarded individuals, parents, employees of the Division of Retardation, and other concerned citizens.

56. The Division should emphasize and clarify to all current and future employees at all levels that a Superintendent's responsibility for monitoring and guiding programs includes even those programs which are outside the domains of his formal training.

57. Florida Child Abuse laws should be revised to include mentally retarded and mentally ill persons over the age of 17 years.

58. There should be professional peer review of all programs which includes documentation in professional literature that the procedures used are not experimental. Any new or experimental programs shall be subject to the rules on human experimentation as set forth in present Divisional guidelines.

59. The Committee recognizes great value in the content of the exit interview procedure. It is recommended that they be considered a major tool for the identification of abuse as well as other problem areas. It is further recommended that these data be supplemented by a similar questionnaire to be given to each

employee at the time of his semi-annual evaluation and that these questionnaires also be sent directly to the Division Central Office. These reports should receive confidential and high priority attention by high level Division personnel. These reports should also be made available to the State Advocacy Program director.

60. In Miami Sunland:

61. Cottage and medical records should be more carefully and completely made. Each entry should be signed. The institutitions' physicians should become more receptive to cooperation with community physicians who are caring for residents. A medical advisory team should periodically evaluate the medical department and report their findings to the superintendent.

62. A program of reorientation for current staff should be established immediately. Institution-wide in-service training programs should be conducted on regular schedules. In-service training programs should include interpretation of the goals of the institution to staff members at all levels.

63. Known instances of abuse should be reported under Florida Child Abuse laws.

64. A comprehensive program needs to be immediately re-established for the Achievement cottages.

65. The present seclusion practices should be abandoned in favor of more positive and appropriate "time out" techniques. No exceptions to existing institution policies regarding restraint should be permitted.

66. The bizarre examples of punishment cited in this report should be specifically prohibited.

EXHIBIT "A"

M E M O R A N D U M

TO: Resident Abuse Investigating Committee

FROM: Jack McAllister, Director, Division of Retardation

SUBJECT: Proposed Objectives for Consideration

DATE: April 5, 1972

Prior investigations relating to reported child abuse have generally revealed that when detected such abuses have been responsibly acted upon by Sunland Training Center, Miami's administration. These investigations have indicated that reported abuses were generally isolated rather than concentrated in any particular campus location. Furthermore, such abuses have been considered as violations of the rules and regulations of Sunland Training Center, Miami as well as of the Division of Retardation. More recently, Sunland Training Center, Miami, has made reports under Florida's recently revised Child Abuse Act. The crisis situation currently at hand is the recent discovery by the Division of Retardation that abusive techniques have been used in a prescribed manner with the residents in a particular cottage in the Achievement Division.

Documentation indicates that these abusive procedures were used with the knowledge of and/or under the direction of certain Sunland Administrative officials.

Although the project in question generally is considered to be one of behavior modification, it appears to the Division of Retardation that the project has vastly exceeded acceptable aversive reinforcement standards through use of its punishment program. Therefore the resident abuse investigation committee is needed by the Division of retardation to:

1. determine whether or not the punishment pratices that have existed in Flagler Cottage, Achievement Division can in fact be considered abusive

2. if so, determine whether abusive pratices as reported in the Log Books of Flagler Cottage exist in Leon and Desoto cottages

3. determine by spot check if prescribed punishment procedures are or have been utilized in other divisions at Sunland Training Center, Miami

4. If the Achievement Division appears to be the focal point for administering sanctioned or prescribed resident abuse then the Division of Retardation needs to know:

    a. why has the situation developed

    b. what individuals are responsible for instituting the abusive procedures

    c. what is the degree of responsibility of:

        1. cottage parents who administered abusive punishment

        2. supervisors who direct or oversee the administration of the techniques

        3. program directors who prescribe or otherwise authorize the continuation of these procedures or their superiors up to and including the superintendant of the Sunland Training Center, Miami

        4. the Division of Retardation in terms of administration or policy strengths or weaknesses relating to detection, monitoring or taking remedial action against such abuse practices.

5. If it is determined that abuse exists at Miami Sunland Training Center, the Committee should attempt to determine the accountability in this particular situation of those employees and/or officials who conceived, authorized, directed, condoned or administered abusive practices or techniques with regard to Sunland Training Center, Miami, residents.

6. If such abuses exist, what recommendations does the Resident Abuse Investigation Committee have for remedying the present situation and preventing its future occurance.

BACKGROUND INFORMATION

1. The Division of Retardation Personnel Handbook which is distributed to every employee states under Section 1. Resident Abuse--"any type of physical or mental abuse to residents makes an employee subject to immediate dismissal. Under no circumstances are employees allowed to strike or commit any form of harmful action against a resident."

2. A policy formulated by the Director of the Division of Retardation and amplified on April 4, 1967 states that no child or resident of a Sunland insitution is to be physically harmed or struck by an employee. Any violations are to be reported immediately in writing to the director of the Division of Retardation and shall contain all facts relating to incidents, witnesses and information which will be helpful in determining if Florida Laws have been violated.

3. Section 828.041, Florida Statutes include the following definitions:

   Definition of a child--a child is a person under the age of seventeen

   Definition of Abuse--neglect, malnutrition, severe physical injury inflicted other than by accidental means and failure to provide sustenance, clothing, shelter and physical conditions

   Section 828.041, Florida Statutes requires that any physician, nurse, teacher, social worker or employee of a public or private facility serving children who has reason to believe that such a child is subject to abuse, shall report or cause such report to be made to the Department of Health and Rehabilitative Services. The law specifies that an oral report shall be made immediately by telephone or otherwise, followed by a report in writing as soon after as possible. The law also grants immunity to those reporting, from liability, civil and criminal.

EXHIBIT "B"

LIST OF PERSONS INTERVIEWED BY RESIDENT ABUSE INVESTIGATION COMMITTEE

John S. Stokesberry	Director of Programs and Services
Harry Howell	Acting Superintendent
William S. Samford	Superintendent, STC at Fort Myers
Leslie W. Alker	Psychologist, V.R.Division
Jack W. McAllister	Director, Div. of Retardation
Frank Maas	Cottage Parent (no longer employed by STC)
Don R. Gustine	Director of Training
Mrs. Mary Rayder	Cottage Group Shift Supervisor II (Suspended)
Mr. Ulysses Davis	Assistant Cottage Life Director
Mr. George E. Dewey	Personnel Manager
Mr. Al Altuve	Program Director, V.R.Division
Mr. John S. Acosta	Cottage Life Director (Suspended)
Dr. Alex Bannatyne	Psychologist,Consultant to BKR Project
Father Gabriel O'Reilly	Catholic Chaplian (Volunteer)
Mr. William S. Kirkpatrick	Project Director, BKR
Mr. Robert L. Eaton	Assistant Director, Div. of Retardation
Mr. Anthony W. Mixon	Personnel Officer, Div. of Retardation
Mr. Coachman	Cottage Parent (suspended)
Mr. Thompson	Cottage Supervisor, (suspended)
Mrs. Harris	Cottage Supervisor
Dr. Dennis Edinger	Staff Psychologist
Miss Busch	Nursing Technician
Dr. Robert Allen	Research Psychologist

Vincent James	resident
Tim Thomas	resident
Donald Brown	resident
Steve Harper	resident
Nola Mathis	former employee
Christina Conroy	former employee
Mary E. Moore	parent
Hans Lankutis	former employee
John Parsons	cottage supervisor
Linda Fordham	former cottage parent trainee
A.E. and Betty Collazo	parents
Mrs. Pignataro	parent
Mr. & Mrs. Geldon	parents
Irene Lakness	parent (son died)
Charles Harper	former employee
Mr. Ellis	parent
Mrs. Vaden	parents
Shirley Schekman	parent
Barbara Hagen	
Ellen Cohen	student at Barry College
Mr. Alker	
Dr. Gonzales-Carbo	Sunland Psychiatrist
Dr. Toister	Sunland Consultant
Dr. Wallach	"
Dr. Feldman	"
Mrs. Mickey Mack	parent
Mr. Hans Lankutas	former employee
Mr. Morris Weiss	parent

THE FOLLOWING INDIVIDUALS WERE INTERVIEWED BY MISS ROWAN OR MISS NORLEY:

Joanne Baker	former employee
Clara Simon	parent
Mrs. Mange	former employee
Renie Zibman	voluntter
Mr. & Mrs. Murick	parents
Blanche Weiss	parent
Dorothy Fegan	parent
Joyce Golden	parent
Fred Slater	parent
Sam Schneider	grandparent
Mrs. Stosic	parent
Mrs. Simons	parent
Patricia Bethel	student at Barry College
Alex Polgart (?)	parent; food service director
Mrs. Bradsma	parent
Mrs. Heal	parent